CHICO STATE WellCat | HEALTH CENTER

400 W. 1st Street
Chico, CA 95929-0777
Phone: 530-898-5241
Fax: 530-898-4057

Medical Treatment Consent Form – Underage Patient

I hereby authorize the WellCat Health Center at Chico State, herein WCHC, to provide to my minor child (less than 18 years of age) any diagnostic tests or treatment that are deemed advisable, and are to be provided by any medical practitioner of the WCHC or any outside physicians or facilities as needed. This authorization is given in advance of any specific diagnosis or treatment that may be required.

Student Name: _____Student ID:_____

Date of Birth:_____

Parent/Guardian Name (Print):_____

Parent/Guardian Signature: _____

Parent/Guardian Address:_____
Street Address City State Zip

Parent/Guardian Phone Number:_____ ◯Home ◯Cell ◯Work

HEALTH CENTER USE ONLY		
Parent/Guardian authorization given:	Yes	No
Consent for the above-named minor given by:		
Relationship to patient:	Parent	Guardian
Verification of relationship completed via:	Phone Call	
Date and time of consent:		
Witness (WCHC staff member)		